NR 601 Week 3 Discussion 2 Solution

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Total Points Possible: 70

Requirements:

Anxiety and depression are the most common psychiatric problems you will encounter in your primary care practice.

Review this case study

HPI: BT, a 50-year-old Caucasian male presents to the office with complaints of “no energy and staying in bed all day.” These symptoms have been present for about 4 months and seem worse in the morning. It is hard to get out of bed and get the day started because he does not feel rested when he gets up in the morning. BT reports “deep sadness & heartache over the loss of his wife”. States” I really don’t feel like making plans or going out”.

He tries to make plans with family or friends once a week, but it can be really exhausting because everyone asks about how he is handling the loss. Reports he also has difficulty completing projects for work, he cannot stay focused anymore. He reports not eating regularly and has lost some weight. BT has been a widower for 10 months. His wife died unexpectedly, she had an MI. His oldest daughter has a 2-year-old daughter. She asked him to babysit a couple of times, which he thought would help with the loneliness, but the care of his granddaughter seems overwhelming at times.

Rest, evening walks, & lifting weights 2 days a week help him feel better. At this time, he does not want to do any activities or exercise, it seems like too much effort to get up and go. He has not tried any medications, prescribed or otherwise. He reports drinking a lot of coffee, but that does not seem to help with his energy levels.
Current medications: Tylenol PM about once a week when he can't sleep, does not help. NKDA.

PMH: no major illnesses. Immunizations up to date. COVID Vaccinated.

SH: widowed, employed part time as a computer programmer. Drinks 1 beer almost every night. No tobacco use, no illicit drug use. Previously married 25 years ago, reports a passive aggressive, abusive relationship that ended in divorce. The judge gave full custody of his children to his ex-wife.

The last time he saw his son was10 years ago. He lives in another state. He sees his daughter 1-2 times a month. He would like to talk to his son but he is concerned the relationship cannot be repaired because he moved out during the divorce.

FH: Parents are alive and well. Has a daughter 20 and a son 18.

ROS

CONSTITUTIONAL: reports weight loss of 4-5 pounds, no fever, chills, or weakness reported. Daily fatigue.

HEENT: Eyes: No visual loss, blurred vision, double vision or yellow sclera. Ears, Nose, Throat: No hearing loss, sneezing, congestion, runny nose or sore throat.

CARDIOVASCULAR: No chest pain, chest pressure or chest discomfort. No palpitations or edema.

RESPIRATORY: No shortness of breath, cough or sputum.

GASTROINTESTINAL: Reports decreased appetite for about 4 months. No nausea, vomiting or diarrhea. No abdominal pain or blood.

NEUROLOGICAL: No headache, dizziness, syncope, paralysis, ataxia, numbness or tingling in the extremities. No change in bowel or bladder control.

GENITOURINARY: no burning on urination.

PSYCHIATRIC: No history of diagnosed depression or anxiety. Reports history feeling very sad and anxious about the loss of wife. Sad about not speaking to his son. Did not seek treatment. He started to feel better about the loss of his wife after 6 months but the grief and depression has returned.

ENDOCRINOLOGIC: No reports of sweating, cold or heat intolerance. No polyuria or polydipsia

ALLERGIES: No history of asthma, hives, eczema or rhinitis.

Discussion Questions for NR 601 Week 3 Discussion 2 Solution

- Research screening tools for depression and anxiety. Choose one screening tool for depression and one screening tool for anxiety that you feel are appropriate to screen BT.

- Explain in detail why each screening tool was chosen. Include the purpose and time frame of each chosen tool.
- Score BT using both of your chosen screening tools based on the information provided (not all data may be provided, those areas can be scored as not present). Pay close attention to the listed symptom time frame for your chosen assessment tool. In your response include what questions could be scored, and your chosen score.
- Interpret the score according to the screening tool scoring instructions. Assume that any question topics not mentioned are not a concern at this time.
- Identify your next step for evaluation and treatment for BT. Remember to consider both physical and mental health differential diagnoses when answering this question. (2-3 sentences).
- What medication or treatment is appropriate for BT based on his screening score today? Provide the rationale. Any medications should include the medication class, mechanism of action of the medication and why this medication is appropriate for BT. Include initial prescribing information.
- If the medication works as expected, when should BT expect to start feeling better?

Direct Quotes

Good writing calls for the limited use of direct quotes. Direct quotes in discussions are to be limited to one short quotation (not to exceed 15 words). The quote must add substantially to the discussion. Points will be deducted under the grammar, syntax, APA category.

Dr. Burks and Class,

The tools that I would use would be the PHQ-9 for depression and the GAD-7 for anxiety. The initial reasoning for the use of these tools are ease of use and both tools can be quickly applied. Despite our desires to spend hours with each patient, we all understand and know that time is of the essence in a primary care setting.

Nonetheless, the PHQ-9 is one of the most validated tools in mental health and can help clinicians with diagnosing depression and monitoring if the chosen treatment was effective. According to Williams (2014), the PHQ-9 assists with the diagnosis of major depression and with symptom severity, furthermore, it has been proven to be useful for the geriatric population. The GAD-7 is utilized to screen for anxiety. It is 70-90% sensitive and 80-90% specific across disorders / cutoffs.

“The GAD-7 is useful for initial screening and measuring symptom severity. While a score of 10 or greater indicates GAD, scores of 5, 10, and 15 indicate mild, moderate, and severe GAD, respectively” (Posmontier & Breiter, p. 271, 2012). Whereas, the PHQ-9 scores 9 items 0-3, it has been stated by some research that certain scores on the PHQ-9 correlate with a major depression diagnosis. However, not everyone with an

elevated PHQ-9 is certain to have major depression. The PHQ-9 is intended as a tool and is not a substitute for diagnosis by a trained clinician.

Using the information already obtained the score for KB on the PHQ-9 would be: moderate to moderately severe depression. The GAD-7 score would be: inconclusive regarding anxiety or a score not exhibiting GAD.

The first thing I think would be important would be to ask additional questions in order to clarify that depression is a concern to her. The first line of treatment for depression would be a SSRI according to Gautam, Jain, et al., (2017). My choice would be Celexa 20 mg PO QD along with follow up with a mental health specialist.

Celexa is an SSRI, the reason is according to Gautam, Jain et al., (p. S38, 2017) “is that in general all the antidepressants have been shown to have nearly equal efficacy in the management of depression”. As the name states, Celexa, selectively inhibits serotonin reuptake. I need to let the patient know it may take up to 4 weeks before she starts to feel better.

Celexa 20 mg

Disp # 30

Sig: 1 tablet daily

RF: 5

References For NR 601 Week 3 Discussion 2 Solution

- Gautam, S., Jain, A., Gautam, M., Vahia, V. N., & Grover, S. (2017). Clinical Practice Guidelines for the Management of Depression. Indian Journal of Psychiatry, 59(Suppl 1), S34–S50. http://doi.org/10.4103/0019-5545.196973
- Posmontier, B., & Breiter, D. (2012). Continuing Education: Managing Generalized Anxiety Disorder in Primary Care. The Journal for Nurse Practitioners, 8, 268–274. https://doi-org.chamberlainuniversity.idm.oclc.org/10.1016/j.nurpra.2011.09.018
- Williams, N. (2014). PHQ-9. Occupational Medicine (Oxford, England), 64(2), 139–140. https://doi-org.chamberlainuniversity.idm.oclc.org/10.1093/occmed/kqt154

NR 601 Week 3 Assignment -Psychiatric Disorders (LINK)

Patient Health Questionnaire (PHQ – 9) – Depression Screening

The Patient Health Questionnaire (PHQ – 9) depression screening tool is widely used in screening patients for depression in nonpsychiatric settings (Manea, Gilbody, & McMillan, 2015). It integrates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a short self-report tool.

The screening rates the frequency of the symptoms, factoring the scoring severity index. One of the most important questions is question 9 that screens for presence and duration of suicidal ideation. I chose this as my depression screening tool to use in the primary care setting. Because it is brief and very useful in preventing patient harm.

NR 601 Week 3 Case Study Assignment (LINK)

Discussion Part One

Katie Smith, a 65 year-old female of Irish descent, is being seen in your office for an annual physical exam. You are concerned since she has rescheduled her appointment three times after forgetting about it. She and her husband John are currently living with their daughter Mary, son-in-law Patrick, and their four children. She confesses that while she loves her family and appreciates her daughter's hospitality, she misses having her own home. As she is telling you this, you notice that she develops tears in her eyes and does not make eye contact with you.

- Background:
    - Although Mrs. Smith is scheduled for an annual physical exam and reports no particular chief complaint, you will need to complete a detailed geriatric assessment. Katie reports a lack of appetite. She tells you that she nibbles most of the time rather than eating full meals. She also reports having insomnia on a regular basis.
- PMH:
    - Katie reports a recent bout of pneumonia approximately 3 months ago, but did not require hospitalization. She also has a history of HTN and high cholesterol.
- Current medications:
    - HCTZ 25 mg daily

        - Evista 60 mg daily
        - Multivitamin daily
- Surgeries:
    - Appendectomy as a child in Ireland (date unknown)
    - 1968- Cesarean section
    - Allergies: Denies food, drug, or environmental allergies
- Vaccination History:
    - Cannot remember when she had her last influenza vaccine
    - Does not recall having received a Pneumovax
    - Her last TD was greater than 10 years ago
    - Has not had the herpes zoster vaccine
    - Screening History:
    - Last Colonoscopy was 12 years ago
    - Last mammogram was 4 years ago
    - Has never had a DEXA/Bone Density Test
- <u>Social history:</u>

- Emigrated with her husband from Ireland in her 20s and has always lived in the same house until recently. She retired a year and a half ago from 30 years of teaching elementary school; has never smoked but drinks alcohol socially. She states that she does not have an advanced directive, but her daughter Mary keeps asking her about setting one up.

- Family history:

    - Both parents are deceased but lived disease-free up into their late 90s. She has one daughter who is 44 years old with no chronic illness and two sons, ages 42 and 40, both in good health.

Discussion Day 1:

- Differential Diagnosis with rationale
- Further ROS questions needed to develop DD
- Based on the patient data provided, choose geriatric assessment tools that would be appropriate to use in conducting a thorough geriatric assessment. Provide a rationale on why you are choosing these particular tools.

Discussion Part Two (Graded)

- Physical examination:
- Vital Signs:

- Height: 5’0” Weight: 150 pounds BMI: 29.3 BP: 120/64 T: 98.0 oral P: 68 regular R: 16, non-labored
- HEENT: Normocephalic, symmetric. Evidence of prior cataract surgery in both eyes. PERRLA, EOMI, cerumen impaction bilateral ears.
- NECK: Neck supple; non-palpable lymph nodes; no carotid bruits. NR 601 Week 3 Discussion 2 Solution
- LUNGS: Clear to auscultation
- HEART: RRR with regular without S3, S4, murmurs or rubs.
- ABDOMEN: Normal contour; active bowel sounds, LLQ tenderness.
- PV: Pulses are 2+ BL in upper and lower extremities; no edema. No evidence of peripheral neuropathy.
- NEUROLOGIC: Negative
- GENITOURINARY: No CVA tenderness
- MUSCULOSKELETAL: Gait fluid and steady. No muscle atrophy or asymmetry. Full ROM all joints. Strength 5/5 and equal bilaterally. Joint swelling in fingers both hands.
- PSYCH: Flat affect; patient declined to answer PHQ-9 and GDS
- SKIN: Grossly intact without rashes or ecchymosis.

Discussion Part Two:

Summarize the history and results of the physical exam. Discuss the differential diagnosis and rationale for choosing the primary diagnosis. Include one evidence-based journal article that supports your rationale and include a complete treatment plan that includes medications, possible referrals, patient education, ICD 10 Codes, and plan for follow up.

DISCUSSION CONTENT NR 601 Week 3 Discussion 2 Solution			
Category	**Points**	**%**	**Description**
Application of Course Knowledge	**21**	**30**	1. Initial discussion post includes the following: 2. two screening tools chosen- 1 for depression, one for anxiety 3. Student explains rationale for both screening tool choices (2-3 sentences) 4. Both screening tools are scored using provided case study information only AND scores are interpreted using tool scoring guidelines. 5. Next steps for treatment include physical health diagnoses and suggested necessary diagnostics 6. Medication choice is listed. Rationale includes medication class, mechanism of action and initial prescribing information and education to include side effects and when BT should notice efficacy.

Support from Evidence-Based Practice (EBP)	**14**	**20**	1. Discussion post is supported with appropriate, scholarly sources; AND 2. Sources are published within the last 5 years; AND 3. Reference list is provided and in-text citations match; AND 4. Includes a minimum of one scholarly reference, textbook is not used
Interactive Dialogue	**21**	**30**	1. Student provides a substantive* response to at least one topic-related post of a peer; AND 2. Student provides a substantive response to any faculty questions asked regarding the initial student post. 3. Evidence from appropriate scholarly sources is included; 4. Submits a minimum of two posts on two different days. (*) A substantive post adds new content or insights to the discussion thread and information from student's original post is not reused in peer or faculty response
	56	**80%**	**Total CONTENT Points= 56 points**
DISCUSSION FORMAT			
Category	**Points**	**%**	**Description**
Organization	**7**	**10**	1. Discussion is presented in a logical format, AND 2. Responses are in sequence with the listed bullet points AND 3. The discussion response is understandable and easy to follow AND 4. All responses are relevant to the discussion topic.

Grammar, Syntax, Spelling & Punctuation	**7**	**10**	Discussion post has minimal grammar, syntax, spelling, punctuation, or APA format errors*
	14	**20%**	**Total FORMAT Points= 14 points**
			DISCUSSION TOTAL=____ out of 70 points